| IPDR6702 | | | | NORTH CAROLINA | | Dh | GE: 1 | |
|-----------|-----------------|-------------|-----------|---|---------|---------|-----------|--------|
| RUN DATE: | 12/10/2006 | | IPR | NORTH CAROLINA S CHECKWRITE SUMMARY REPORT | | PA | · | |
| | | | С | HECKWRITE DATE: 12/12/2006 | | | | |
| | | | 1 | FINANCIAL PAYER: NCDMH | | | | |
| | | | | | | | TOTAL | TOTAL |
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 2404001 | | 0525 | | | | | | |
| 3404901 | SMOKY MOUNTAINM | 8535 | 1 | SERVICE FACILITY LOCATION WAS NOT SUBMITTED ON THIS CLAIM. | | | | |
| | H/DD/SAS | | | PLEASE RESUBMIT THE CLAIM WITH | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 1 | 6 | 5 |
| | | | | | | | | |
| 3404904 | WESTERN HIGHLAN | 3413 | 87 | PROVIDER TYPE AND SPECIALTY 07 | | | | |
| | DS LME | | | 4/113 CANNOT BILL ENHANCED | | | | |
| | | | | BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | | | | | | |
| | | 8536 | 11 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT | 0 | 119 | 2594 | 2475 |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| | | | | | | | | |
| | | 8534 | 8 | SERVICE FACILITY LOCATION IS N | | | | |
| | | | | OT A VALID IPRS ATTENDING | | | | |
| | | 1 | | PROVIDER. PLEASE VERIFY THE F | | | | |
| 3404910 | PATHWAYS | 8933 | 62 | ADTNC INELIGIBLE TO RECEIVE SE | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | | 47 | OF VEHICLE WAS DEVOTED BY ABBUTAN | | | | |
| | | 11 | 47 | CLIENT NOT ELIGIBLE ON SERVICE DATE | 89 | 208 | 780 | 572 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8536 | 46 | ATTENDING PROVIDER TYPE AND SP | | | | |
| | | | | ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR | | | | |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| 3404912 | CATAWBA COUNTYM | 8935 | 7 | ASTNC INELIGIBLE TO RECEIVE SE | | | | |
| | ENTAL HEALT | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | 70 | - | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | | 79 | 3 | YOUR SUBMITTED BILLING | 7 | 16 | 479 | 463 |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | | | | | | |
| | | 191 | 2 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | | | H PATIENT NAME | | | | |
| | | | | | | | | |
| 3404913 | MECKLENBURG COM | 8518 | 49 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | ENTAL HEALT | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | 143 | 46 | CLIENT ID NUMBER NOT ON STATE | | | | _ |
| | | 143 | 40 | ELIGIBILITY FILE | 0 | 114 | 114 | 0 |
| | | | | - | | | | |
| | | | | | | | | |
| | | 191 | 18 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | 1 | | H PATIENT NAME | | | | |
| | | | | | | | | |
| 3404916 | CROSSROADS BEHA | 21 | 13 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | VIORAL HEAL | | | | | | | |
| | | | | | | | | |
| | | 8599 | 6 | DETAIL NOT COVERED BY COMBINAT | 0 | 22 | 400 | 457 |
| | | 1 | | ION OF RECIPIENT, PROVIDER AND | U | 23 | 480 | 457 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8534 | 1 | SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING | | | | |
| | | 1 | | OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F | | | | |
| | | | | | | | | |
| 3404917 | CENTERPOINT HUM | 8599 | 63 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | AN SERVICES | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | - | | BENEFIT PACKAGE. | | | | |
| | | 8935 | 35 | ASTNC INELIGIBLE TO RECEIVE SE | 51 | 207 | 6253 | 6046 |
| | | | | RVICES IN IPRS. | 21 | 207 | 6253 | 0046 |
| | | | | | | | | |
| | | | | | - | | | |
| | | 21 | 27 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | L | 1 | 1 | | | | L | |

| | | | | | | | TOTAL | TOTAL |
|--------------------|--------------------------------|--|----------------------|---|----------------|---------|---------------------|----------------|
| PROVIDER NUMBER | PROVIDER NAME | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC DENIALS | TOTAL | CLAIMS FINALIZED | CLAIMS PAID |
| | PROVIDER NAME | | | | DENIALS | DENIALS | FINALIZED | PAID |
| 3404919 | GUILFORD CO MEN | 8599 | 108 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | TAL HEALTHC | | | BENEFIT PACKAGE. | | | | |
| | | 120 | 23 | CLIENT ID NUMBER MISSING OR IN | | 105 | 2770 | 2502 |
| | | 120 | 2.5 | VALID. ENTER CID AND SUBMIT | 13 | 195 | 3778 | 3583 |
| | | | | AS A NEW CLAIM | | | | |
| | | 191 | 21 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | | | H PATIENT NAME | | | | |
| | | | | | | | | |
| 3404920 | ALAMANCE CASWEL | 8505 | 1712 | CLAIM DENIED DUE TO INSUFFICIE NT BUDGET | | | | |
| | L AREA MH D | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 8599 | 143 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | 0 | 1958 | 2718 | 760 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 21 | 48 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | | | | |
| 3404921 | ODANICE DEDCOM C | 8505 | 1352 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | ORANGE PERSON C HATHAM AREA | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 670 | 124 | OTHER DIAGNOSIS CODE 4 IS INVA | 0 | 1800 | 4468 | 2668 |
| | | | | LID | | | | |
| | | + | | | | | | |
| | | 27 | 99 | DIAGNOSIS CODE MISSING OR INVA | | | | |
| | | | | LID. VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUB | | | | |
| | | | | | | | | |
| 3404922 | THE DURHAM CENT | 21 | 367 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | ER ER | | | | | | | |
| | | 191 | 79 | CLIENT ID NUMBER DOES NOT MATC | 7 | 534 | 2425 | 1891 |
| | | | | H PATIENT NAME | , | 334 | 2423 | 1091 |
| | | | | | | | | |
| | | 8622 | 36 | 60 RESIDENTIAL LEVEL II TREATM | | | | |
| | | | | ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE. | | | | |
| | | | | TON IDDITIONAL CONTROL | | | | |
| 3404923 | FIVE COUNTY MH | 8536 | 134 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT | | | | |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| | | | 22 | | | | | |
| | | 11 | 33 | CLIENT NOT ELIGIBLE ON SERVICE DATE | 0 | 243 | 2487 | 2244 |
| | | | | | | | | |
| | | 3411 | 19 | PROVIDER TYPE AND SPECIALTY 07 | | | | |
| | | | | 4/113 CANNOT BILL ENHANCED | | | | |
| | | | | BENEFIT SERVICES ON OR AFTER D | | | | |
| 3404925 | SANDHILLS CENTE | 8532 | 328 | SUBMITTED BILLING PROVIDER IS | | | | |
| | R FOR MH/DD | | | NOT ELIGIBLE FOR DATE OF SERVICE BILLED | | | | |
| | | | | | | | | |
| | - | 21 | 66 | DUPLICATE OF CLAIM-SYSTEM | 13 | 652 | 8350 | 7698 |
| | | | | | | | | |
| | | 8599 | 63 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | 1 | | | | | |
| 3404926 | SOUTHEASTERN RE | 8599 | 44 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | G MENTAL HL | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | + | | DENDETI FAURAGE. | | | | |
| | | 143 | 16 | CLIENT ID NUMBER NOT ON STATE | 1 | 92 | 2428 | 2336 |
| | + | | - | ELIGIBILITY FILE | | | | |
| | | 101 | | | | | | |
| | | 191 | 14 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | | | | |
| | | | | | | | | |
| 3404927 | CUMBERLAND CO M | 8518 | 21 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | CUMBERLAND CO M HC | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | 8599 | 14 | DETAIL NOT COVERED BY COMBINAT | 1 | 71 | 1013 | 942 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | - | | | BENEFIT PACKAGE. | | | | |
| | | 5404 | 12 | SEVERE DUPLICATE: SAME ATTD PR | | | | |
| | | | - | OV/PCODE/TOS/DOS/MOD | | | | |
| | | 5404 | 12 | SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD | | | | |

| PROVIDER | | HIGH DENIAL N | NUMBER OF | | muo | moma v | TOTAL | TOTAL |
|----------|-----------------|---------------|-----------|--|---------|---------|---------------------|----------------|
| NUMBER | PROVIDER NAME | | DENIALS | DESCRIPTION | TNC | TOTAL | CLAIMS FINALIZED | CLAIMS PAID |
| | PROVIDER WANE | | | | DENTALS | DENTALS | FINALIZED | FAID |
| | | | | | | | | |
| 3404930 | JOHNSTON COUNTY | 8952 | 1 | CLAIM DENIED DUE TO AGE RESTRI | | | | |
| | MNTL HLTHC | | | CTIONS FOR TARGET POPULATION | | | | |
| | | | | | | | | |
| | | 0 0 | n | | | | 2.4 | 0.0 |
| | | | | | U | 1 | 24 | 23 |
| | | | | | | | | |
| 3404931 | WAKE CO HUM SVC | 8599 4 | 43 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | BILLING OF | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 8535 | 9 | SERVICE FACILITY LOCATION WAS | | | | |
| | | 0333 | | NOT SUBMITTED ON THIS CLAIM. | 0 | 49 | 68 | 19 |
| | | | | PLEASE RESUBMIT THE CLAIM WITH | | | | |
| | | | | | | | | |
| | | 191 2 | 2 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | | | H PATIENT NAME | | | | |
| | | | | | | | | |
| 2404022 | | 0526 | 140 | AMMENIATAC PROLETER MUNE AND OR | | | | |
| 3404933 | SOUTHEASTERN CT | 8536 | 148 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT | | | | |
| | R FOR MH/DD | | | VALID FOR SUBMITTED BILLING PR | | | | |
| | | | | | | | | |
| | | 120 | 111 | CLIENT ID NUMBER MISSING OR IN | 0 | 380 | 2955 | 2575 |
| | | | | VALID. ENTER CID AND SUBMIT | | 300 | 2333 | |
| | | | | AS A NEW CLAIM | | | | |
| | | | | | | | | |
| | | 8599 | 89 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| 3404934 | ONSLOW CARTERET | 8534 6 | 602 | SERVICE FACILITY LOCATION IS N | | | | |
| | BEHAV HEAL | | | OT A VALID IPRS ATTENDING | | | | |
| | DDIIIV IIDID | | | PROVIDER. PLEASE VERIFY THE F | | | | |
| | | | | | | | | |
| | | 8536 2 | 240 | ATTENDING PROVIDER TYPE AND SP | 0 | 1508 | 2103 | 595 |
| | | | | ECIALTY COMBINATION IS NOT | | | | |
| | | | | VALID FOR SUBMITTED BILLING PR | | | | |
| | | | | | | | | |
| | | 11 | 171 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| 3404935 | WAYNE CO MENTAL | 0 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | HEALTH CTR | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 0 (| 0 | | 0 | 0 | 0 | 0 |
| | | | | | | | | |
| 2404026 | | 2510 | | AND THE PROPERTY OF THE PROPER | | | | |
| 3404936 | WILSON-GREENE M | 8518 | 15 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | ENTAL HEALT | | | FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | | 1100111 111111 1000 (0011 1 00111 | | | | |
| | | 0 (| 0 | | 0 | 15 | 2514 | 2499 |
| | | | | | | 13 | 2314 | 2.33 |
| | | | | | | | | |
| | | | | | | | | |
| 3404937 | EDGECOMBE NASH | 8518 | 15 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | MNTL HLTH C | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | 21 | 7 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | , | DOLDIGHTS OF CHAIN-SISIEM | 0 | 23 | 483 | 460 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8952 | 1 | CLAIM DENIED DUE TO AGE RESTRI | | | | |
| | | | | CTIONS FOR TARGET POPULATION | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404939 | NEUSE MENTAL HE | 8518 | 8 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | ALTH CENTER | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | 1 | | |
| | | 8532 | 6 | SUBMITTED BILLING PROVIDER IS | | 1 | | |
| | | 222 | ~ | NOT ELIGIBLE FOR DATE OF | 0 | 19 | 810 | 791 |
| | | | | SERVICE BILLED | | | | |
| | | | | | | | | |
| | | 8537 | 3 | PROCEDURE IS NOT PAYABLE FOR Y | | | | |
| | 1 | 1 | | OUR PROVIDER TYPE AND | | | | |
| | | 1 | | | | | | |
| | | | | SPECIALTY IN ACCORDANCE TO MEN | | | | |

| | | | 1 | | 1 | | TOTAL | TOTAL |
|----------|--------------------------------|-------------|-----------|---|--|---------|-----------|---------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| | | | | | | | | |
| 3404941 | PITT CO MH/DD/S | 8518 | 2420 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | AS CENTER | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | | | | | | |
| | | 8534 | 903 | SERVICE FACILITY LOCATION IS N | 0 | 4106 | 5595 | 1489 |
| | | | | OT A VALID IPRS ATTENDING | | | | |
| | | | | PROVIDER. PLEASE VERIFY THE F | | | | |
| | | | | | | | | |
| | | 120 | 240 | CLIENT ID NUMBER MISSING OR IN | | | | |
| | | | | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | | | |
| | | | | AS A NEW CLAIM | | | | |
| 3404942 | | 21 | 9 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 3404342 | ROANOKE CHOWANH | 2.1 | 2 | DOFFICATE OF CHAIM-SISTEM | | | | |
| | UMAN SERVIC | | | | | | | |
| | | | | | | | | |
| | | 8518 | 2 | CLAIM DENIED, SUBMITTED BEYOND | 0 | 5 | 41 | 36 |
| | | | | FILING TIMELIMIT. PRIOR | | , | 41 | 30 |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | | | | | | |
| | | 3411 | 1 | PROVIDER TYPE AND SPECIALTY 07 | | | | |
| | | | 1 | 4/113 CANNOT BILL ENHANCED | | | | |
| | | | + | BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | 1 | | | | | |
| 3404943 | ALBEMARLE MENTA | 8536 | 39 | ATTENDING PROVIDER TYPE AND SP | | | | |
| | L HEALTH CE | | 1 | ECIALTY COMBINATION IS NOT | 1 | | | |
| | | | 1 | VALID FOR SUBMITTED BILLING PR | 1 | | | |
| | | | 1 | | 1 | | | |
| | | 3411 | 14 | PROVIDER TYPE AND SPECIALTY 07 | 3 | 87 | 1103 | 1016 |
| | | | | 4/113 CANNOT BILL ENHANCED | | | | |
| | | | | BENEFIT SERVICES ON OR AFTER D | | | | |
| | | | | | | | | |
| | | 8599 | 9 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| 3404944 | EASTPOINTE HUMA | 8534 | 63 | SERVICE FACILITY LOCATION IS N | | | | |
| | N SERVICES | | | OT A VALID IPRS ATTENDING | | | | |
| | | | | PROVIDER. PLEASE VERIFY THE F | | | | |
| | | | | | | | | |
| | | 8518 | 11 | CLAIM DENIED, SUBMITTED BEYOND | 0 | 91 | 645 | 554 |
| | | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | | | | | | |
| | | 79 | 5 | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | | | | YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404946 | FOOTHILLS AREAM | 8599 | 138 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | ENTAL HEALT | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 21 | 128 | DUPLICATE OF CLAIM-SYSTEM | 4 | 529 | 4547 | 4018 |
| | | | 1 | | ļ | | | ļ |
| | | | 1 | | | | | |
| | | 142 | 0.0 | CLIENT ID NUMBER NOT ON STATE | 1 | | | |
| | | 143 | 98 | | 1 | | | |
| | | | + | ELIGIBILITY FILE | 1 | | | |
| | | | + | | 1 | | | |
| 3404957 | manual and control | 8599 | 21 | DETAIL NOT COVERED BY COMBINAT | 1 | | | |
| | TIDELAND MENTAL | 3333 | | ION OF RECIPIENT, PROVIDER AND | 1 | | | |
| | HEALTH CTR | | + | BENEFIT PACKAGE. | | | | |
| | | 1 | + | | | | | |
| | | 8931 | 10 | AMTNC INELIGIBLE TO RECEIVE SE | 12 | 43 | 333 | 290 |
| | | | + | RVICES IN IPRS. | 12 | 4.3 | 333 | 290 |
| | | | + | ** | | | | |
| | | | + | | | | | |
| | | 8518 | 5 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | | | + | FILING TIMELIMIT. PRIOR | | | | |
| | | | + | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | + | | | | | |
| | | | 200 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| 3404979 | NEW RIVER AREAM | 8518 | 388 | | | | | |
| 3404979 | NEW RIVER AREAM H/DD/SA PRO | 8518 | 388 | FILING TIMELIMIT. PRIOR | | | | |
| 3404979 | NEW RIVER AREAM H/DD/SA PRO | 8518 | 388 | | | | | |
| 3404979 | | 8518 | 388 | FILING TIMELIMIT. PRIOR | | | | |
| 3404979 | | 8518 | 123 | FILING TIMELIMIT. PRIOR | 0 | 547 | 2576 | 2029 |
| 3404979 | | | | FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE | 0 | 547 | 2576 | 2029 |
| 3404979 | | | | FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE | 0 | 547 | 2576 | 2029 |
| 3404979 | | 21 | | FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE DUPLICATE OF CLAIM-SYSTEM | 0 | 547 | 2576 | 2029 |
| 3404979 | | | | FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE | 0 | 547 | 2576 | 2029 |